UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ARAVA (leflunomide)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- **DOCUMENTED** Severe Rheumatoid Arthritis
- **DOCUMENTED** history of treatment, incomplete response or intolerance to Methotrexate
- **DOCUMENTED** 6 or more swollen joints
- **DOCUMENTED** 9 or more tender joints
- **DOCUMENTED** rheumatology consultation within the last 60 days.
- May not be given with other biologic agents such as Interferon, experimental medications or combinations.

AUTHORIZATION:

Initial prior is for 6 months.

RE-AUTHORIZATION:

Subsequent PA is for 12 months if the patient has at least 20% **DOCUMENTED** improvement in 4 of the following 6 areas: tender and swollen joint count, patient and or global assessment of disease activity, pain, acute phase reactants.